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O. C. WELBOURN, A. M., M. D., Editor

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From a Logia Overlooking the Prado, San Diego

The California Eclectic Medical Journal

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Original Contributions

LARYNGEAL DIPHTHERIA, OR MEMBRANOUS CROUP

W. A. Harvey, M. D., San Francisco.

Read before the California Eclectic Medical Society.

Having been called to treat this disease recently prompts me to write on this subject. I do not propose to go into an exhaustive description of this disease, but I do wish to emphasize a few points. That branch of modern medicine known as bacteriology has proven that membranous inflammation beginning in the larynx is almost invariably due to the Klebs-Loeffler Bacillus and constitutes true diphtheria. Membranous Laryngitis following the acute exanthemata or membranous inflammation of the pharynx, nose or tonsils is occasionally due to other forms of germs, mostly streptococci but more often is due to the Klebs-Loeffler bacillus. In cases of primary laryngeal diphtheria most of the characteristic symptoms which mark diphtheria of the pharynx are absent, for the reasons that the former frequently runs such a rapid course, producing death, from local causes, before the constitutional symptoms resulting from the absorption of the toxin have developed and owing to the fact that the mucous membrane of the larynx is feebly supplied with lymphatics, the absorption of poison is slow as compared to the pharynx; therefore, glandular enlargements, albuminuria and asthenic symptoms are generally lacking, as are many of the post-mortem changes.

Symptoms: In the onset membranous laryngitis, or croup—I use the term croup because I wish to impress upon those not accustomed to considering membranous croup as

diphtheria, that they are one and the same thing, with the few exceptions previously noted—cannot be distinguished from the catarrhal form. It is usually a trifle less abrupt and not quite so severe for the first twenty-four hours. We have the same hoarse cough and voice, with dyspnea, which generally increases; temperature ranges from 99 to 101; pulse accelerated but not weak. It is the progress of the disease during the first twenty-four to thirty-six hours that usually indicates its character. During the second twenty-four hours the symptoms are generally characteristic—from hoarse cough and voice it becomes a metallic, whistling cough, with aphonia. The dyspnea growing more marked, pulse grows weak, and the endeavor to acquire and the necessity for oxygen become very apparent.

Diagnosis: Whether these symptoms are due to pneumonia, foreign bodies or retro-pharyngeal abscess are usually easily determined by a careful examination. It is not practicable to get cultures of bacilli from the larynx, but we must rely on swabs taken from the pharynx. Membranous inflammation should be assumed if there is severe, constant and increasing croupy cough, with dyspnea and aphonia, and all such cases should be regarded as diphtheria until proven otherwise by numerous negative results.

Treatment: One word is all I wish to add to the treatment that would otherwise be employed by Eclectics, and that word is Antitoxin, which should be administered early and in full doses. No one should hesitate to employ it when statistics from numerous sources have proven that the mortality in cases of diphtheria has been reduced from eighty per cent to less than six when antitoxin is administered not later than the third day of the disease. Concluding, my desire is to emphasize the necessity of early diagnosis of membranous laryngitis. The fact that it should always be assumed to be diphtheria, and to urge the early use of antitoxin in full doses.

THE USE OF GALVANO CAUTERY IN HYPERTROPHIC RHINITIS.

H. W. Hunsaker, M. D., San Francisco.

Read before the California Eclectic Medical Society.

This is not a new subject, by any means, as Galvano Cautery has been used in catarrhal conditions of the nose

since, perhaps, 1854, but it was called to my attention a short time ago in reading an article written by Dr. Greenfield Sluder of St. Louis in which he describes his technique and the conditions in which he recommends it.

The technique of using Galvano Cautery as described by the doctor is not new to me, although a part of his method is.

He describes a platinum loop for stripping off the middle turbinate in the anterior portion. I have never used this method and have never found such radical cautery necessary. Where he burns a straight line through the posterior extremity of the inferior turbinate and then a fork from the terminus of this line to the eustacian eminence, it has been my practice for many years to endeavor to burn all of the diseased surface of the posterior extremity of the inferior turbinate, and when the eustachian eminence is badly swollen I also sink the electrode into its base.

In the great majority of cases of post-nasal catarrh, where the posterior extremity of the inferior turbinate looks like a big strawberry, there is usually a catarrhal condition of the eustachian tubes resulting from irritation or infection from the turbinate body, and to relieve the tubal catarrh it is necessary to remove the diseased tissue of the adjacent turbinate.

There are many people who have a slow but sure deterioration in their hearing, due to no other cause than the condition just mentioned, and in all cases of partial deafness, whether there has been middle ear affections or not, the tube and the adjacent structure should be carefully examined, that is, the posterior turbinates and the tonsils.

Doctor Sluder has devised an ingenious instrument for retracting the palate so that he can work through the mouth, but a pair of soft rubber tubes of the proper length passed through the nose and drawn through the mouth and tied will effectually hold the soft tissue forward so that the field of operation will be clear in the laryngoscope, and with a flexible electrode made of copper wire of sufficient size to give it just enough resistance to be bent in any direction and insulated to the point, will do the work better than any rigid, fixed electrode, as in my work I shape the electrode to fit each individual case and usually repeat the operation in about two or three weeks.

The majority of cases can be cleared up in two operations and not destroy the healthy tissue. In undertaking to re-

move large growths by cautery at one sitting we are apt to have an annoying post-operative hemorrhage. Occasionally the condition is so exaggerated that it requires three or four sittings to clear up the diseased tissue.

PERSONAL EXPERIENCE WITH DRY DIET.

Herbert T. Webster, M. D., Oakland, Cal.

About 1907, approximately, I had an opportunity to treat a case of acute tuberculosis with dry diet. In this case I believe I would have succeeded, except for an accident. The patient was a woman, about the change, who had been a patron of mine for ten years or more, calling me frequently to treat her children as well as herself for more or less trifling ailments. I had not seen her for a year, when she called at the office for medicine for a cough. I was shocked at the change that had occurred in her since our last meeting. She was emaciated, haggard and pallid, with hectic spots on the cheeks, and a racking cough, with expectoration, was much in evidence. She coughed in the hallway before entering the office, nearly all the while when there, and when she went out. She had been intending to call on me for some time for treatment, but had put it off because she was too busy. A wealthy father had recently died and left her a large estate, and she had been too busy attending to it to attend to herself.

I found a temperature of 103 degrees, rapid pulse, and crepitus and rales all over the thorax. She slept little nights on account of the cough, and confessed to having lost considerable weight within the past few weeks. She thought it would be a small matter for me to give her some medicine to cure the cough, and was amazed when I told her the case was a very serious one, and explained more fully its nature. I broached the dry diet treatment, but she evidently thought I was mistaken, for she immediately went to another physician, who made light of what I had told her, pronounced it acute bronchitis, and proposed to treat her successfully with medicine. In two or three weeks she sent for me to visit her at her home and told me what she had done, and that the other physician had finally advised her to go to Arizona for a change of climate. He had changed his mind. She had talked the matter over with her husband and children, and concluded she preferred to die at home rather than in Arizona among strangers. Therefore, she wanted to try the dry diet treatment.

This case received the best I could afford it, after my experience with Dr. Weber's treatment of myself. I put her on the improved dry diet and applied light packs to the chest, which were changed at intervals, and continued until they became irksome to the patient and no longer seemed to afford comfort. Within six weeks the cough and expectoration ceased, the lungs cleared up, the appetite grew better, and the patient was more cheerful and hopeful. She was waited upon by her daughters and husband, who tried to carry out orders faithfully. When the ninth week was nearly up, my hopes were very high, for the urine was nearly cleared, temperature was normal, and I expected to soon begin the recuperative treatment. About this time I was summoned urgently to the house one evening and found my patient comatose. One of the daughters informed me that she was suddenly seized with delirium, soon became paralyzed on one side, and sank into unconsciousness in a short time. She died within twenty-four hours, without regaining consciousness.

This was a great disappointment to me. I speculated upon the sudden change, and could come to but one conclusion, and that was that a cerebral meningeal tubercle had softened and broken down, causing the sudden and fatal change. It acted somewhat like an apoplexy of the brain, but the effect of the treatment is to lessen blood pressure, and she was hardly a subject, in her emaciated condition, for cerebral apoplexy. Scattered tubercles are common in acute tuberculosis. The effect of dry diet is to soften and break up tubercle, but in such a case as tubercular meningitis fatal result must necessarily follow breaking up.

In addition to this experience I shall chronicle a brief account of another case of acute tuberculosis with which I came in contact in the dry diet line. It teaches one lesson, at least, and that is, in practicing dry diet one never knows "where he is at."

A young man in the vicinity of my home became the subject of pulmonary tuberculosis. The family was Swedish, of the uneducated kind. The young man, about nineteen years of age, was his mother's only support, and she was heartbroken. The boy had been working away from home, in a distant part of the state, and had been sent home to die, by the local physician. I was sent for with the hope that I would disagree with the diagnosis, but could not. I expressed the opinion that there was only one hope for him, and broached the dry diet treatment. This was before Drs.

Henderson and Von Unruh had loomed upon the horizon. The mother was eager to have it tried, and the patient was willing and anxious.

I described the treatment briefly, and warned them of its many discouragements, assuring them that there would be opposition on all sides. However, they decided that the boy should begin at once. I began with moderate restriction of drink, and allowed the patient dry boiled chicken twice a week, with stale bread for regular diet. I visited him every three days, to keep his courage up. At the end of a month the cough and expectoration had ceased, the lungs were clearing up, and I was pleased and encouraged, though one bad symptom attended, and that was, the bowels moved regularly, and the mother assured me that the patient was taking no physic. Soon now, however, it became evident that adverse influence was at work. The mother began to complain bitterly that the boy was being starved, and I suspected that my probation was short. Upon my next visit I found the patient reticent and moody, and not inclined to pay any attention to what I said to him. I concluded that my usefulness in that case had terminated, but decided, as I had not been dismissed, to call again.

Three days later I went to the house. The front door was open, but no one answered the bell; it seemed as though everybody about the place had vamoosed. I walked through the hall to the kitchen, where I had met the patient before, and found him there alone, seated at the table, before a huge platter of mutton chops, flanked by a large dish of potatoes, bread and butter, and other things "good to eat." I remarked: "Well, you seem to be having a good time." "Yes," he replied, "I have been starving long enough." "All right," I said, "you evidently have no more use for me, so I will not call again." I learned afterward that he already, at that time, had had several doses of tuberculin injected. They had changed doctors, but had failed to notify me. He died within two months afterward.

I then determined that I would never attempt another case of dry diet unless I could have the patient under my personal supervision, where meddlesome outsiders could be excluded. Also, I determined that a large fee should be paid down, as a forfeit, if the patient should "crawfish." I am not looking for, craving, nor expecting such a case. I am contented with things as they are, and will try to worry along without practicing the dry diet system.

Nevertheless, I found myself engaged in another experi-

ence of this kind. In March, 1916, I was called to San Francisco to see a case of supposed chronic articular rheumatism. At least, the patient and her friends regarded it as such, though how her former physicians could have been so deceived is a puzzle. Probably they understood the case well enough, but did not care to enlighten those most interested. It was a case of arthritis defórmans. The patient had just emerged from a ten months' stay at a hospital, where she had been subjected to serum or bacterium hypodermic treatments. From these she had suffered greatly, but had received no benefit. The case had been standing two and a half years.

There was ossification of new connective tissue about all the articulations of the extremities. She waddled into the room to meet me in a squatting position, turning her face upward to greet me, with her forearms half flexed, in the deplorable condition such cases are found. She was gradually growing worse, according to the testimony of herself and sister, who was taking care of her. She was married and the mother of two little boys. Large bony protuberances over the carpoulnar articulations distorted the wrists, the fingers were misshapen, though she still had some use of the hands. The muscles of the forearms were atrophied almost to the bones, there was little power of rotation, and little ability of flexion or extension of the forearms. The knees were so distorted that the patellae were indistinguishable to palpation, being buried among pathological bony excrescences. The morbid growths were hard and resistant to pressure—apparently true bone.

There was marked tachycardia, the pulse registering 128 per minute. The appetite and digestion, however, were fairly good, though there had been abscence of the menses for several months. Temperature normal.

I informed the patient that it was not rheumatism, but something much more difficult to treat. I told her that such cases had never been benefited by medicine, and I knew of but one possibility for any benefit to be derived from treatment in her case, and that even then it was a matter of question and experiment. I assured her that the treatment was severe and nerve racking, and advised her to think well before she entered upon it, as I would promise nothing, short of twelve weeks' trial. I explained the process of dry diet to her, and suggested that she think it over well before deciding.

The following day I received a letter from her sister,

informing me that the patient had decided to give the treatment a trial. I therefore visited her and put her on the treatment, the technique of which I have described in the July number of Ellingwood's Therapeutist. She continued the treatment faithfully for fourteen weeks, with remarkable fortitude. I shall append some brief notes made from my own observation, made upon weekly visits.

At the end of the first week the pulse had been reduced from 128 to 80 per minute; temperature slightly subnormal. Patient acknowledged considerable thirst, but with little resort to liquids between regular drinks was able to get along tolerably well. Urine coffee-colored and throwing down considerable white sediment, gritty to feel.

Second week, pulse 76, temperature 97½. Tongue coated white, but not heavily. Bowels moved about every fourth day, without meddling.

Third week, tongue cleared, and urine amber in color, but still throwing down white sediment. I was now surprised to find that upon firm pressure upon the excrescences they yielded, leaving temporary indentations.

Fourth week, pulse 60, temperature 97. Patient declined to stay in bed, but preferred to assist her sister in light duties about the kitchen, but was sleepy much of the time, and took her forenoon and afternoon naps. Chilliness was a prominent symptom, and warm clothing was enjoined, and a bag of hot water to the feet when in bed. Sleeping well at night.

Fifth week, pulse 60, temperature 97. Increasing softening of the excrescences. Patellae now distinguishable to palpation, and movable. Crackling about the knee-joints when walking. Thinks she can extend her legs more than before treatment began. Patient dressed and about, but sleeps much during the day. Tongue clean, and digestion unimpaired. Cheerful, and resolved to persevere. Progressive softening and diminishing of excrescences.

Sixth week, patient cheerful and holding on to treatment. Excrescences becoming soft and fluctuating under pressure, and lessening in size. Pulse 56 per minute, temperature 97. Urine still throwing down much white, gritty sediment. Patient stands much more erect, and walks, after some effort in assuming it, in nearly an erect position. Knees crackle when walking, and also elbow joints when passive movement is exerted in rotation.

Seventh week, pulse 70, temperature 97. Patient suffers less from drink restriction. Patellae can now be defined by

vision, though yet buried in abnormal growth, which, however, is still softening. Menses still absent.

Treatment was thus continued to the end of the thirteenth week, when she became very tired and felt that she was losing strength. Had to hold on to table and chairs when walking. Thinking it about time to give the patient a little rest, I allowed twelve ounces of fluid per day. Circumstances rendering it difficult for me to visit her again for some time, I ordered her to have a soft-boiled egg and a cup of coffee for breakfast, continuing regular treatment after that.

Circumstances prevented my visiting this patient for more than a month afterward, July 19th. The excrescences over the carpoulnar articulations were reduced to mere watery blebs, the bony articulation clearly definable to palpation. Patient walks almost erect, but joints still crackle. Feels strong on improved diet, but wants to go to the mountains for a change of air. Is delighted with the improvement she has made, and determines to return to the regular treatment after a few months' rest.

I believe this treatment will radically cure recent cases of arthritis deformans.

BOARD OF MEDICAL EXAMINERS.

State of California.

ANATOMY AND HISTOLOGY.

William R. Molony, M. D.

June 27, 1916—9 to 11:30 a. m.

(For Physicians and Surgeons and 2000 Hours Drugless Applicants.)

1. (a) What structures are derived from the epiblast; hypoblast; mesoblast?
   (b) Simple tissues of the human body may be divided into five classes. Name and define each class.
2. Briefly describe the heart; location; relation to chest wall and vertebrae; composition and arrangement of walls; nerve and blood supply; valves and endocardium.
3. Describe the mandible (inferior maxillary bone).
4. Give the histology of lung tissue.
5. Briefly describe the ovary. Give its relations; blood and nerve supply. Define ovulation; graafian follicle; corpus-luteum.

6. If the abdominal aorta be ligatured two inches superior to its bifurcation, how may a collateral circulation be re-established below the ligature?
7. Describe the hip joint, naming muscles passing across the joint.
8. Differentiate bursae mucosum and bursae synovial. Locate five important examples of each kind.
9. Name and locate the ganglia that communicate with the branches of the fifth cranial nerve; give the anastamoses of the branches of the first and second divisions of the fifth cranial nerve.
10. Give the insertion and nerve supply of the following muscles: Soleus; tibialis postius; pronator radii teres; scalenis anticus; quadratus femoris; biceps femoris; sartorius; obturator internus; platysma; temporal.
11. Give the origin and nerve supply of the following muscles: Trapezius; gastrocnemius; latissimus dorsi; biceps cubiti; sterno mastoid; omo-hyoid; pectoralis minor; brachio-radialis; rectus femoris; internal oblique.
12. Give the action of any ten muscles of the foregoing groups.

(Answer ten questions. When possible, arrange your answers in columns; be brief and to the point.)

GENERAL MEDICINE.

Robert A. Campbell, M. D.

June 27, 1916—1 to 3 p. m.

(For Physician and Surgeon Applicants.)

1. What are the causes of hemorrhoids? Tell how the causes named produce them.
2. What complications may develop during or following acute gonorrhoeal urethritis?
3. Discuss empyemia.
4. Upon what would you base a diagnosis of a tumor of the cerebellum?
5. Discuss tuberculosis of the spine.
6. Describe an attack of acute lobar pneumonia.
7. Describe the lesion of secondary syphilis.
8. Differentiate chancre, chancroid and herpes. When would you consider the case with the chancre cured?

9. What is the significance of a systolic blood pressure of 165 in a man of fifty? What should be done for him?
10. Diagnose and treat a case of acute anterior poliomyelitis.
11. Give etiology and treatment of a case of la grippe.
12. What is the significance:
    (a) of a tarry stool;
    (b) a clay colored stool;
    (c) a greenish frothy stool;
    (d) a hard lump stool?

(Answer ten questions only.)

BACTERIOLOGY AND PATHOLOGY.

Dain L. Tasker, D. O.

June 27, 1916—3:30 to 6 p. m.

(For Physician and Surgeon Applicants.)

1. Define three varieties of cysts and give an example of each.
2. What forms may hemorrhage take and what is the fate of the effused blood?
3. What are ptomains, toxalbumen, leukomains?
4. Discuss arrythmias of the heart, with special reference to heart block and fibrillation.
5. What is a parasyphilitic condition?
6. Of what help is embryology in the study of pathological conditions of the male genital tract?
7. Mention four diseases of protozoan origin and give short description of the causal organisms.
8. Discuss serum sickness.
9. Discuss chromogenic bacilli.
10. Discuss artificial immunization against typhoid fever and smallpox.
11. Discuss the pneumococcus of Frankel and the pneumobacillus of Friedlander.
12. Differentiate gonococci from other cocci in pus from the uretha.

(Answer ten questions only.)

PHYSIOLOGY.

Ernest Sisson, D. O.

June 28, 1916—10 a. m. to 12 m.

(For Physician and Surgeon and 2,000 Hours Drugless Applicants.)

1. Describe how the distribution of blood is regulated on change of position.

2. Explain the influence of the vagus nerve on respiration.
3. In what does the peristalsis of the oesophagus differ from other parts of the alimentary canal?
4. How do the movements of the large intestine differ from those of the small intestine?
5. Discuss causes, mechanical and nervous, in the call to defecation.
6. Why is it that living tissue resists many influences which attack dead tissue with disastrous effect?
7. Discuss the maintenance of the rhythmical beat of the heart.
8. Describe by diagram and text the growth and development of a nerve cell.
9. What effect will transfusion of a moderate amount of fluid have upon the blood pressure? Explain why.
10. Why do we not have coagulation of blood within the living vessels?
11. Outline a normal pulse tracing and explain the elevations and their relations.
12. Explain how the blood retains its alkalinity against an excessive acid diet.

(Answer ten questions only.)

OBSTETRICS AND GYNECOLOGY.

H. V. Brown, M. D.

June 28, 1916—1 to 3 p. m.

For Physician and Surgeon and 2,000 Hours Drugless Applicants.)

1. Desribe syphlitic ulcer of the cervix uteri.
2. Give causes and treatment of cervical stenosis.
3. Discuss the merits of Cesarean section compared with other methods of relieving dystocia.
4. Describe the operation of Cesarean section.
5. What structures are divided in a complete laceration of the perineum? Describe in full operation for repair.
6. (a) Discuss non-specific cystitis in its relation to Gynecology.
   (b) Discuss constipation in its relation to Gynecology.
7. Give treatment of severe erosion and eversion of cervix with excessive muco-purulent discharge in woman pregnant at three months.

8. (a) Describe the fetal circulation and indicate changes occurring at birth.
   (b) What is a blue baby?
9. Give preventive treatment of:
   (a) Mastitis;
   (b) Ophthalmia neonatorum;
   (c) Puerperal infection;
   (d) Postpartum hemorrhage.
10. Give differential diagnosis of pregnancy and distention of uterus due to retained menses.
11. When and how would you employ the following drugs in labor: Ergot, pituitrin; quinin; scopolomin; lobelia; gelsemium.
12. (a) When first consulted by a primipara, what should be the scope of your examination?
    (b) Why should an examination be made six to eight weeks following delivery?

(Answer ten questions only.)

SURGERY.

Percy T. Phillips, M. D.

June 28, 1916—3 to 5:30 p. m.

(For Physician and Surgeon Applicants.)

1. Describe in detail treatment of lacerated wound of scalp involving periosteum, and discuss possible dangers of improper treatment.
2. What are the most important factors concerned in extensive postoperative thrombosis and embolism? Discuss the precautionary measures suggested for their prevention.
3. Classify ileus. Give symptoms and treatment.
4. Give some of the causes of delayed union in fractures and the treatment you would adopt for each of these causes.
5. Give indications for paracentesis membrani tympani. Describe operation in detail. What structures should be especially avoided.
6. Describe in detail and give method of reduction of backward dislocation of the thumb at the metacarpo phalangeal joint.
7. How would you treat a penetrating wound of the cornea with incarceration of the iris?

8. Discuss hydro-nephrosis. Give treatment.
9. Discuss retro-pharyngeal abscess. Give treatment in detail.
10. Give symptoms and signs of malignancy of mammary gland.
    Give surgical treatment in detail.
11. Give causes and symptoms of fracture of base of skull.
12. Give etiology, pathology, symptoms, differential diagnosis and treatment of acquired flat-foot.

(Answer ten questions only.)

MATERIA MEDICA, THERAPEUTICS, PHARMACOLOGY AND PRESCRIPTION WRITING

H. E. Alderson, M. D.

June 29, 1916—10 a. m. to 12 m.

(For Physician and Surgeon Applicants.)

1. Write a complete prescription for a 120 c.c. soln. containing tincture of nux vomica (0.5 c.c. to the dose) for internal use, and describe the therapeutic indications and the contra-indications for the same.
2. Discuss the medical treatment of constipation in a woman fifty years of age.
3. Give the dosage of strychnine sulphate and of opium and discuss the action of each on the alimentary tract.
4. Discuss the dosage and mode of using calcium internally and its therapeutic action.
5. Discuss the dosage, modes of administration and therapeutic action of sodium phosphate.
6. Discuss fully the precautions to be taken in the use of mercury in the treatment of syphilis.
7. Discuss the general principles that should guide one in the therapy of typhoid fever.
8. Discuss the treatment of ankylostemiasis (uncinariasis), also the prophylaxis.
9. Discuss the therapy of rabies.
10. Discuss the medical treatment of diabetes mellitus.
11. Discuss the medical and dietetic treatment of early arteriosclerosis.
12. Discuss the therapy of mercurial stomatitis.

(Answer ten questions only.)

ECLECTIC MATERIA MEDICA, THERAPEUTICS, PHARMACOLOGY AND PRESCRIPTION WRITING.

H. V. Brown, M. D.

June 29, 1916—10 a. m. to 12 m.

(For Physician and Surgeon Applicants Only.)

1. What is a specific tincture?
2. Discuss the therapeutics of nux vomico.
3. What are the active principles of ipecac; physostigna; hyoscyamus; belladonna?
4. Name three vegetable drugs in the nerve sedative class and differentiate the uses of each.
5. Discuss the advantages of small doses of aconite frequently repeated as compared with a full therapeutical dose given at one time.
6. Write a prescription for enuresis and discuss the management of the case in general.
7. What drugs would you use in a case of tinea saginata? Discuss the treatment and prognosis.
8. What drugs have a selective action on the prostate gland?
9. Discuss the uses of collinsonia in laryngitis and hemorrhoids.
10. State source and physiological action of jaborandi; cannabis indica.
11. Discuss digitalis fully.
12. Write a prescription for a case of diabetes mellitus with persistent slate colored stool.

(Answer ten questions only.)

HOMOEOPATHIC MATERIA MEDICA, THERAPEUTICS, PHARMACOLOGY AND PRESCRIPTION WRITING.

Robert A. Campbell, M. D.

June 29, 1916—10 a. m. to 12 m.

(For Physician and Surgeon Applicants.)

1. Name three remedies useful in bronchial pneumonia with the indications for each.
2. Describe the conditions of the alimentary canal calling for merc. corr; arsenicum alb; nux vomica and lycopodium.

3. Discuss cactus grandaflora.
4. Tell how you would treat a case of acute articular rheumatism.
5. Write a prescription containing three drugs and a vehicle. Describe the conditions for which you would prescribe it.
6. Give treatment of a case of carbolic acid poisoning; of corrosive sublimate poisoning.
7. Describe the headache calling for belladonna; spigelia; sangunaria and nux vomica.
8. Name and give dosage of two drugs which will make urine acid and two which will make it alkaline.
9. Do vaccines act homeopathically? If so, how? If not, why not?
10. What would you give for the following case: Dry hacking cough, pain sharp and cutting in the chest, relieved by lying on affected side, worse from being moved, has delirium going over the details of his work, stool dry and hard?
11. Give the indications for china, ipecac, geranium and hydrastis in hemorrhage.
12. When and how would you use pituitrin; camphorated oil; adrenalin; novacain? Give strength and dosage of each.

(Answer ten questions only.)

CHEMISTRY AND TOXICOLOGY.

H. Clifford Loos, M. D.

June 29, 1916—1 to 3 p. m.

(For Physician and Surgeon,)

1. (a) What is organic chemistry?
   (b) What are the general characteristics of organic compounds?
2. Name the principal derivatives of hydrocarbons.
3. Give general characteristics of metals of the iron group.
4. What does illuminating gas contain generally, and why is it toxic?
5. Give by volume, by weight, and by molecular weight, the components of water.
6. Write equation showing action of sulphuric acid on sodium chlorid.

7. Give a test for sulphuric acid in vinegar.
8. Name five elements used in pure state in medicine.
9. What is the chemical treatment for creosote poisoning?
10. Mention antidotes for iodin poisoning.
11. Give a test for determining the presence of strychnine.
12. What metallic chemical substances are found in the body?

(Answer ten questions only.)

HYYGIENE AND SANITATION.

A. M. Smith, M. D.

June 30, 1916—10 a. m. to 12 m.

(For Physician and Surgeon and 2,000 Hours Drugless Applicants.)

1. Discuss the sanitation of an encampment of five thousand soldiers.
2. Define humidity of the atmosphere. What classes of diseases are most prevalent in a humid atmosphere?
3. What measures should be used on shipboard, or in camp, to eradicate scurvy?
4. What is sewer gas? How does the inhalation of sewer gas affect the svstem?
5. Discuss the agency of ptomaines in inducing diseases.
6. Name and describe the methods of five important infections and contagious diseases.
7. Discuss the prophylaxis of typhoid fever.
8. Give the medical and hygienic plan for the inspection and care of immigrants arriving at a seaport.
9. Discuss the theory of hereditary tendencies as applied to tuberculosis.
10. Describe the best method for eradication of hookworm from a community.
11. Give the prophylaxis of filth diseases.
12. Discuss the care of milk from dairy to customer.

(Answer ten questions only.)

THE CALIFORNIA ECLECTIC MEDICAL JOURNAL

The Official Organ of the Eclectic Medical Society of the State of California, the Southern California Eclectic Medical Association and the Los Angeles Eclectic Medical Society.

Contributions, Exchanges, Books for Review and all other communications should be addressed to THE CALIFORNIA ECLECTIC MEDICAL JOURNAL, 819 Security Building, Los Angeles, California. Original articles of interest to the profession are solicited. All rejected manuscripts will be returned to writers. No anonymous letters or discourteous communications will be printed. The editor is not responsible for the views of contributors.

PUBLICITY PAYS!

This couplet is a slogan with the people who have advertising space to sell. And, whether it be true or not, they certainly practice what they preach by constantly keeping this allegation before the eyes of the people. Let us admit, therefore, that advertising pays and pass on to a consideration of the matter advertised. Usually it is something new. It may be breakfast food, a patent medicine or what not; but it is always something new. Its many virtues are presented in a most alluring manner, with especial emphasis on the "new." It is the very latest style, the last step in that fox-trot sometimes called progress. Acareful perusal of the advertisement will frequently show that, assuming that all its statements are facts, it is in no way better than the article it is designed to supplant. However, it takes and the old is discarded. And then we wonder what becomes of the hosts of the past—the old ideas, the old foods, the old clothes! But who cares? We of the present age are thoughtless of the past and heedless of the future. The present is the life and we are interested in the fads thereof. And so, publicity pays.

PREVENTION OF INFANTILE PARALYSIS.

By United States Public Health Service.

To control the present epidemic of infantile paralysis, according to a statement issued by the United States Public Health Service today, the chain of infection between persons harboring germs of the disease and the well members of the community should be broken. Infantile paralysis is probably caused by a very minute organism found in the nasal, mouth and bowel discharges of those who have the disease or who are carriers of the germ without themselves suffering from the ailment. All of the steps in the spread of the infection are not known, but if this germ can be prevented from passing from the infected to the well person, the disease will cease.

Infantile paralysis is not a disease of recent origin. Sporadic or scattered cases have occurred throughout the country for many years, but it is only during the last decade that the infection has assumed epidemic proportions in the United States. The present epidemic in New York City, on account of its magnitude and virulence, has awakened the residents of many communities to the danger of the importation of the disease into their own midst. This danger is real, but if due precautions are exercised it is believed that the epidemic will subside.

The actual control of the present epidemic must be left to the city, State and Federal health authorities. These organizations will properly quarantine and care for affected persons, prescribe sanitary measures and limit as may be necessary the travel of individuals in order to protect neighboring districts from the infection. Individuals and communities, however, can do much toward their own protection.

Poliomyelitis is probably spread, directly or indirectly, through the medium of infective secretions. Account must therefore be taken by communities of every means by which such secretions are disseminated. Promiscuous expectoration should be controlled. The common drinking cup affords a method for the interchange of material of this nature and should therefore be abolished. Rigid cleanliness of glasses and utensils at soda fountains, in saloons and other public places should be enforced. Flies, roaches and other vermin, by coming in contact with infective secretions, may possibly convey them to our food and thus directly bring about the development of disease. Therefore, eliminate insects. Street and house dust bear a definite relation to the spread of many

infections, and it is not unreasonable to presume that they may be a factor in the dissemination of infantile paralysis. Maintain strict cleanliness of streets, yards and alleys, in order to prevent the breeding of insects and other vermin. See that all garbage and waste are properly cared for and collected at regular and frequent intervals. Guard all food supplies, especially milk and other perishable products. Digestive troubles of children arising from the ingestion of food of questionable quality may lower resistance. Assemblies of children in infected localities are to be discouraged, if not actually forbidden. While the above measures are in a sense general and applicable to many epidemic diseases, their importance should not be overlooked.

Individual preventive measures may be thus summarized: Summon a physician at once and immediately notify the health officer of the presence of the disease. If the disease is present in the community, medical aid should be sought whenever a child is sick, no matter how light the illness; many cases of infantile paralysis begin with a slight indisposition. Should the illness prove to be infantile paralysis, isolate the patient, place a competent person in charge, and reduce all communication with the sick room to a minimum. Hospital care is preferable, not only for the child but in order to better safeguard against the spread of the disease. The sick room should be well ventilated and screened. Nasal and mouth secretions should be received in cloths, placed in a paper bag, and burned. The clothing of the child, the bed linen, and the excretions should be disinfected in the same manner as for typhoid fever, that is by boiling, the long continued application of 5 per cent carbolic, or other well recognized disinfectant. The same is true for dishes and drinking vessels. Nurses should exercise the same precautions as regards cleanliness of hands in caring for infantile paralysis patients as for those afflicted with other infectious diseases.

A child may convey the disease to others even after a lapse of several weeks. For this reason quarantine should be maintained for a considerable period, usually from six to eight weeks, and the above precautions should be adhered to during this time. Disinfection of the room following recovery is advisable.

DEATH RATES AND EXPECTATION OF LIFE

Director Sam L. Rogers, of the Bureau of Census, Department of Commerce, is soon to issue a unique set of tables, the first of their kind which have ever been prepared by the United States Government. These tables, which were compiled in the division of vital statistics, under the supervision of Professor James W. Glover, of the University of Michigan, show death rates and expectation of life at all ages for the population of the six New England states, New York, New Jersey, Indiana, Michigan, and the District of Columbia (the original death-registration states) on the basis of the population of 1910 and the mortality for the three years 1909, 1910 and 1911. They are similar to the "life tables" prepared by life insurance companies, but differ from them in that they relate to the entire population of the area covered, whereas the life insurance tables relate only to risks selected through medical examination and otherwise.

Expectation of life, at birth, in a stationary population—that is, one in which the births and deaths were equal and were the same from year to year, and in which there was no immigration or emigration—would be the same as average age at death, which is calculated by totalizing the ages of all deceased persons and dividing the result by the number of deceased persons.

Women Live Longer Than Men.—According to these tables the average expectation of life, at birth, for males is 49.9 years; for females, 53.2 years; for white males, 50.2 years; for white females, 53.6 years; for native white males, 50.6 years; for native white females, 54.2 years; for negro males, 34.1 years; and for negro females, 37.7 years. Females are thus longer lived than males to the extent of more than three years, and in the case of the native whites and negroes, more than three and a half years.

The expectation of life at the age of 1 is considerably greater than at birth, being 56.8 years for native white males and 59.5 for native white females, and reaches its maximum at the age of 2, when it is 57.5 for the former class and 60.1 for the latter. At the age of 12 the average native white male's expectation of life is 50.2 years; at 25 it is 39.4 years; at 40, 28.3 years; at 50, 21.2 years; at 60, 14.6 years; at 70, 9.1 years; and at 80, 5.2 years. Similarly, at the age of 12 the average native white female's expectation of life is 52.6 years; at 25 it is 41.8 years; at 40, 30.3 years; at 50, 22.8 years; at 60, 15.8 years; at 70, 9.8 years; and at 80, 5.5 years.

A part of the difference between expectation of life for men and for women is due to the greater number of violent deaths among men. Nearly four-fifths of these violent deaths—suicides, homicides, and accidental deaths—are of males, and such deaths form about 7 or 8 per cent of the total number occurring each year. This fact, however, does not account fully, or even in major part, for the greater longevity of women. An examination of the tables discloses a lower death rate for females than for males during each of the first 12 months of life, and in the case of the native whites, during each year of life up to the age of 94. During the first month of life the death rate among native whites is nearly 28 per cent higher for boys than for girls, and during the first year it is more than 20 per cent higher.

Infant Mortality Still High.—The enormous waste of infant life which still goes on, although medical science has done and is doing much to arrest it, is shown by the exceedingly high death rates which prevail among infants under 1 year of age. Of 100,000 native white boy babies born alive, 4975, or almost 5 per cent, die during the first month, and 12,602, or 12.6 per cent, die within one year. The girl baby's chance of life is considerably better, the death rate among native white females during the first month being 3894 per 100,000 born alive, or less than 4 per cent, and during the first year 10,460 per 100,000, or nearly 10.5 per cent.

On its first birthday, however, the likelihood that a child will die within the year is only about one-fourth as great as it was at birth, the death rate among native whites during the second year being 2841 per 100,000 for males and 2610 per 100,000 for females. The rate continues to decrease until the twelfth year of life—that is, the period between the eleventh and the twelfth birthdays—during which it is only 288 per 100,000 for males and 198 per 100,000 for females. This, the figures indicate, is the healthiest year of life among native whites. Thereafter there is a continuous increase in the death rate from year to year. During the forty-eighth year of life, in the case of native white males, it is 1267 per 100,000, or almost exactly what it was during the third year, 1266; during the sixty-second year it is 2919 per 100,000, or a little more than during the second year, 2841; and during the eightieth year it is 12,184, or somewhat less than during the first year, 12,602. Similarly, among native white females the rate during the fiftieth year, 1120, is a little less than during the third year, 1144; during the sixty-third year it is 2548, or somewhat less than during the second, 2610; and

during the eightieth it is 10,901 per 100,000, or a little more than during the first, 10,460. The native white man at the age of 102 and the native white woman at 99 have approximately the same prospect of dying within one month that they had at birth.

Median Age at Death.—To say that a person's expectation of life is a certain number of years is not the same as saying that he has an even chance of living that number of years. This is because, as already explained, expectation of life represents the average remaining length of life, at any given age, in a stationary population, whereas an average person in a given group has an even chance of living to what is called the median age at death, that is, the age below which half of the members of that group will die. The median age at death for all native white males in the assumed stationary population would be 60; that is to say, of a given number of such males born alive, half would die before reaching 60 and the other half at 60 and beyond. A native white male child at birth, then, has one chance in two of reaching this age. At the end of his first year, however, he has a trifle better than an even chance of reaching 64; and at 42 he has one chance in two of attaining three score and ten. Similarly, a native white female child at birth has an even chance of living a few months past the age of 64; at the age of 1 she has one chance in two of living until she is nearly 68 years old; and at 22 her chance of reaching 70 is an even one. Thus a native white man at 42 and a native white woman at 22 have about the same chances of celebrating their seventieth birthdays.

City and Country.—The relative healthfulness of city and country is strikingly shown by the tables, according to which the death rate among white males under 1 year of age in cities having 8000 inhabitants and over in 1909, and in cities of 10,000 and over in 1910 and 1911, is 13,380 per 100,000 born alive, whereas in smaller places the corresponding rate is only 10,326 per 100,000, or 23 per cent less than the rate for cities. A similar difference prevails with respect to white females under 1 year of age, for whom the death rate in cities is 11,123 per 100,000 born alive, while in rural localities it is only 8497 per 100,000, or 24 per cent less than the urban rate.

For white males the expectation of life, at birth, in rural localities is 7.7 years greater than in cities; at the age of 10, 5.4 years greater; and until the age of 39 is reached there is a margin of more than five years in favor of the country. Thereafter the difference becomes gradually less, but is al-

ways in favor of the country until the age of 88 is reached, at and after which the cities show a slightly greater longevity than the rural localities.

For white females the difference between urban and rural longevity, while pronounced, is somewhat less than in the case of males. At birth the white female's expectation of life is 6 years greater in rural than in urban localities; at 10, 3.3 years greater; and until the age of 46 is attained the difference continues to be more than 3 years. Thereafter it declines until the age of 83 is reached, after which the cities haye a slight advantage over the country.—Ed. Southern Practitioner.

TRUST A WOMAN

C. E. Laws, M. D., Ft. Smith, Ark.

While I was an interne in Cook County Hospital, a young woman we called Mary was admitted to the obstetric ward and assigned to my service. One day, a week or so later, I was stopped in the hall by a middle-aged Irish woman who, from her immense proportions, I supposed to be a candidate for the same ward. The stranger asked if I was Mary's doctor, and in the dialect of one fresh from the Emerald Isle introduced herself as Mrs. Mack, who lived over near the stockyards, saying that she wanted to adopt Mary's baby when it was born, and that Mary was "willin'." Now, I know of no man or set of men who do not say more nearly what they please than the internes of the aforesaid institution. In keeping therewith, I surveyed her with a little more scrutiny and replied that from her appearance it would only be a short time until she had one of her own. Her answer came quick as a flash, "Ay, don't you pay anny attintion to that; thims awnly pellows I'm a wearin' on the froont of me to fool me hoosbint wit," at the same time taking a punch at one of the lower corners that came out into a point and proceeded to round up and press into shape her pendulous abdomen of feathers. In amazement and amusement, I began, "Do you mean to say—" but she evidently guessed the rest and hastened on, "Ye see, me hoosbint is a good mon, and happy he was to think we had a little one a comin.' And when I lost it at three months I never cood tell him the truth." I had recovered enough to venture, "But how," when she cut me off. "Noo can't ye troost a woman for thot? Plinty of hospitals there be aroond here that will do me the favor of a room for a week when I've got the price. Can't ye meck arrangements with the wartin' for

the child and get a nurse-laidy to bring it over to me? I'll give ye me hoosbint's tilephone noomber and glad he will be to get an invitation from ye to coom over and have a look at his awn bebby." I hesitated, thinking, for it was impossible to get my brain to work as fast as that woman's tongue while she unfolded her plan. And before I could utter a word she was asking, "And what will ye charge to deliver me? Twinty-five dollars? Aw I'm goin' to pay ye for ye trooble alright; don't worry about thot, and here's fifteen of it noo. Will ye do ut?"

The sight of the greenbacks helped me to think. Twenty-five dollars, when dollars were cartwheels, and twenty-five of them. Would I do it? Why I would have sold her the hospital for the sum. But before I knew it she was disappearing down the hall, and as I closed my hand over those three five dollar bills I began to see in her case a degree of merit.

Many times after that I had occasion to laugh at those distorted pillows. Too high or too low, and sometimes as square as a checkerboard. Never questioned by the casually observing, even though they be nurses and doctors who continually passed her in the corridors. But I never saw them when they did not need "beating up."

Her program went through without a hitch. Mrs. Mack knew before I, and gave her the information that Mary was "sick." I 'phoned the old Irishman to come over to a nearby hospital and see his fine boy. And I want to say that I never saw a happier father in all the days of my practice. Just two of us knew the truth, and Mr. Mack doesn't know to this day that that baby is not of his own flesh and blood unless she told him, and in her own words, "Ye can throost a woman for that." —N .E. M. A. Quarterly.

SOCIETY CALENDAR

National Eclectic Medical Association meets in Nashville, Tenn., June, 1917. Dr. W. E. Daniels, Madison, South Dakota, President; Dr. Wm. P. Best, Indianapolis, Ind., Secretary.

Eclectic Medical Society of the State of California meets in Santa Barbara, May, 1917. Dr. H. Ford Scudder, Los Angeles, President; Dr. G. H. Greenwell, Los Angeles, Secretary.

Southern California Eclectic Medical Association meets in May, 1917. Dr. H. T. Cox, Los Angeles, President; Dr. H. C. Smith, Glendale, Secretary.

Los Angeles Eclectic Medical Society meets at 8 p. m.

on the first Tuesday of each month. A. P. Baird, M. D., Los Angeles, Cal., President; H. Ford Scudder, M. D., 1621 W. Pico Street, Los Angeles, Secretary.

LOS ANGELES ECLECTIC MEDICAL SOCIETY.

The regular meeting of the Los Angeles Eclectic Medical Society was held on August 1st, 1916, at the offices of Drs. Welbourn, 819 Security Building, at 8 p. m. There was a good attendance and the meeting proved to be unusually interesting. The minutes of the last meeting were read and approved. The next meeting will be on September 5, at the same hour and place. Dr. Oran Newton, Long Beach, will read a paper and Dr. Clinton Roath will give a clinical report.

Adjournment.

A. P. BAIRD, Pres.

P. M. WELBOURN,
Sec. pro tem.

NEWS ITEMS.

Dr. H. Ford Scudder has removed from 1621 West Pico Street, Los Angeles, to Inglewood, California.

Dr. H. W. Crook has changed his address in Long Beach to 323 First National Bank Bldg.

Dr. W. S. Gibson, 1954 East First Street, has changed his address to 529-531 Homer Laughlin Bldg., 315 South Broadway, Los Angeles.

Dr. Leon Patrick, C. E. M. C. 1915, has opened an office at 402 Severance Bldg., 105 West Sixth Street, Los Angeles.

Dr. O. C. Darling, formerly of Riverside, California, was a patient in the Westlake Hospital last month, having had a minor operation.

Dr. R. W. O'Neal of Bishop, California, was a professional visitor at the Westlake Hospital during August.

Dr. G. W. Greenwell, of Los Angeles, has returned from a short vacation spent in San Diego.

Dr. D. A. Stevens has returned to Holtville, Cal., after a few weeks spent in Los Angeles.

Died: Mrs. Aisbitt, wife of Dr. M. S. Aisbitt, Los Angeles, died at the family home on West Fiftieth Street, from paralysis, on August 15.

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Table of Contents

INDEX TO ADVERTISERS

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Table of Contents

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